MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

05910

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lillian Mary Anderson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Married

6.(b) Name of husband or wife John Wesley Anderson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1877

8. AGE:

Years	Months	Days	If less than one day
68	2	26	hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Augustus Bowman

13. Birthplace Md.

MOTHER 14. Maiden name Unk.

15. Birthplace Md.

16. Informant Helen Estella Anderson

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)

Cemetery or crematory St. Luke's Cemetery

Location Sykesville, Md.

18. Funeral director C. Harry Wees

Address Sykesville, Md.

19. June 15 1945 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, 19..., to death 19...

and that I last saw h... alive on June 13 19 45

Immediate cause of death	DURATION
Chronic myocarditis	
Chronic arthritis deformans	
Due to hypertension	
Auricular fibrillation	
Due to Chronic interstitial nephritis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Carmack M.D. M. D. or other

Address Sykesville Date signed 6/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JUN 19 1995

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-D

CERTIFICATE OF DEATH

05911

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll Co

City or town: Hampstead (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Entire life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Henry Edwin Belt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mrs. Virginia Dell Belt

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 13, 1870

8. AGE: Years 75 | Months 1 | Days 17 | If less than one day ____ hrs. ____ min.

9. Birthplace: Hampstead Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Building

FATHER — 12. Name: Geo. W. Belt

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary J. M. Bull

15. Birthplace: Maryland

16. Informant: Marie Belt

Address: Hampstead Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 2 - 45 (month) (day) (year)

Cemetery or crematory: Wesley

Location: Carroll Co. Md

18. Funeral director: Edw Tipton

Address: Hampstead Md

19. June 30 1945 (Date rec'd by registrar) John S. Hughes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30, 1945, at 11.45 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1943, to June 30 1945 and that I last saw h.. alive on June 3 1945

Immediate cause of death	DURATION
Carcinoma of Lung	1 yr
Due to	
Due to	
Other conditions Chr. myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jos. E. Buckland M. D. or other

Address: Hampstead Md Date signed: 6-30-45

VS 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03912

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Years

Hospital, Institution, or street address where death occurred:

31 Carroll St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 Carroll St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mandelia Bemiller

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

B.(b) Name of husband or wife Jacob H. Bemiller

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30 1858

8. AGE:

Years	Months	Days	If less than one day
87	0	5	..... hrs. ..... min.

9. Birthplace Union Mills Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Home-Wife

11. Industry or business

FATHER

12. Name John Dutrow

13. Birthplace Md.

MOTHER

14. Maiden name Sarah Humbert

15. Birthplace Md.

16. Informant Mrs. Iva G. Schaeffer

Address Carroll St. Westminster, Md.

17. Burial Date thereof June 7/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadow Grove

Location near Westminster, Md.

18. Funeral director J. E. Myers Jr.

Address Westminster, Md.

19. 6-7 1945 H. Myers Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5th 1945, at 12 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1945, to June 4th 1945, and that I last saw her alive on June 4th 1945.

Immediate cause of death	DURATION
M. L. Hemiplegia and Heart Failure	
Due to Age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

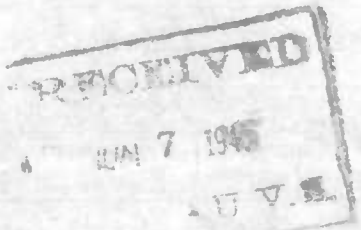
23. SIGNATURE John L. Stewart M. D. or other

Address Westminster Md Date signed June 6th 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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JUN 7 1965

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05913

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 6 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 223 W. Biddle St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN BOYD

3.(b) Social Security Number: lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Jessie Boyd

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 26, 1893

8. AGE: Years	Months	Days	If less than one day
51	6	21	hrs. min.

9. Birthplace: Columbus, S. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Pink Boyd

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: C. D. Lee, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-20-45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location:

18. Funeral director: Adolphus Halstead

Address: 918 Druid Hill Ave

19. 6/15 (Date rec'd by registrar) 1945 Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15, 1945, at 10.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 9, 1945 to June 15, 1945 and that I last saw him alive on June 15, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 26 1942
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C D Lee M. D. M. D. or other

Address: Henryton, Md. Date signed: 6/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

05914

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs. 15 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 7 yrs. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ----------
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DOTTIE OBELIA BUCHANAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Benjamin A. Buchanan

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Jan. 26, 1889

8. AGE: Years	Months	Days	If less than one day
56	5	6	..... hrs. ..... min.

9. Birthplace: Shenendoah County, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Jacob Good
13. Birthplace: Virginia

MOTHER
14. Maiden name: Zirkle
15. Birthplace: Virginia

18. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 6/6/45 (month) (day) (year)

Cemetery or crematory: Gaithersburg

Location: Gaithersburg Md.

18. Funeral director: Ernest B. Gaither

Address: Gaithersburg Md.

19. June 4 1945 (Date rec'd by registrar) Helen M. Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1945 at 8.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1945 to June 1 1945 and that I last saw her alive on June 1 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	unk.
Due to:	
Due to:	
Other conditions: Involutional Melancholia (Include pregnancy within 3 months of death)	8 yrs.

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward F. Kernan M. D. or other

Address: Sykesville, Md. Date signed 6-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-d)

CERTIFICATE OF DEATH

05915

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs 9 mos
Hospital, Institution, or street address (if not in hospital) where death occurred: Springfield State Hospital
How long in hospital or institution? 16 yrs 9 mos

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County [illegible] (North)
City or town Gambrills (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Norman Camp. | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife ✓
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) unknown.

8. AGE: Years 75 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Farm
12. Name of FATHER Peter Camp
13. Birthplace of FATHER Maryland
14. Maiden name of MOTHER Barbary Hoff
15. Birthplace of MOTHER Maryland
16. Informant Mrs. Gilson Camp, Address Gambrills Maryland
17. Burial (Burial, cremation, or removal, Which?) Date thereof June 16, 1945 (month) (day) (year)
Cemetery or crematory Springfield Hosp. Cem.
Location Sykesville Md.
18. Funeral director C. Harry Wiles
Address Sykesville, Md.
19. June 16 1945 (Date rec'd by registrar) C. Harry Wiles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th 1945, at 4-45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12th 1928, to June 14th 1945, and that I last saw h[illegible] alive on June 14th 1945.

Immediate cause of death	DURATION
Due to Chronic Endocarditis	15 yrs
Due to Cerebral Arterio Sclerosis	15 yrs
Other conditions Epilepsy	50 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. H. Hastings M.D. M. D. or other
Address Sykesville Md. Date signed 6/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (36)

CERTIFICATE OF DEATH

Reg. Dist. No. 5916 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 days

Hospital, institution, or street address where death occured: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Ice Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MAY ELIZABETH CHANEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

8.(b) Name of husband or wife: John Chaney

8.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): June 4, 1922

8. AGE:	Years	Months	Days	If less than one day
	23	0	11	...hrs. ...min.

9. Birthplace: Frederick, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER
12. Name: Alexander Scott
13. Birthplace: Ohio

MOTHER
14. Maiden name: Rachel Dorsey
15. Birthplace: Frederick, Md.

18. Informant: George G. Adams, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19-1945 (month) (day) (year)

Cemetery or crematory: Hanover

Location: Frederick, Md.

18. Funeral director: M. B. Eichison and Son

Address: Frederick, Maryland

19. 6/15 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15, 19 45 at 8.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 19 45 to June 15, 19 45 and that I last saw her alive on June 15, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Apr. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George G. Adams M. D. or other

Address: Henryton, Md. Date signed 6/15/45

05917

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Springfield State Hospital
City or town: Sykesville, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster, R. F. D. 5
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Jennie L. Cheatham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John C. Cheatham
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): April 1, 1885

8. AGE: Years	Months	Days	If less than one day
60	2	21	...hrs. ...min.

9. Birthplace: North Brunswick, Canada (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Milton Abner
FATHER 13. Birthplace: Canada
MOTHER 14. Maiden name: Elizabeth ?
MOTHER 15. Birthplace: Canada
16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-25-45 (month) (day) (year)
Cemetery or crematory: Westminster
Location: Westminster Md.
18. Funeral director: J. F. Reese
Address: Westminster md
19. June 22 1945 (Date rec'd by registrar) C. Harry Ebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22, 1945, at 3:40a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945, to June 22 1945 and that I last saw her alive on June 22 1945

Immediate cause of death	DURATION
Cerebral thrombosis	2 wks.
Due to: Generalized arteriosclerosis	unk.
Due to:	
Other conditions: Psychosis & cerebral arteriosclerosis	4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward J. Kernan M. D. or other
Address: Sykesville, Md. Date signed 6-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

05918

★ Reg. Dist. No. 83

1. PLACE OF DEATH:
County: Carroll
City or town: Berrett
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Berrett
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: IDA B. CONAWAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Columbus A. Conaway
deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6, 1865

8. AGE: Years 80 | Months 1 | Days 24 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Warner Pickett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Airy Jenkins
15. Birthplace: Maryland

16. Informant: Mr. Clarence Conaway
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 2, 1945 (month) (day) (year)
Cemetery or crematory: Ebenezer
Location: Winfield, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. July 1 (Date rec'd by registrar) 19 45 Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 19 45 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 41 to June 30 19 45 and that I last saw h[illegible] alive on June 29 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Cardio vascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: N. A. Barnes MD
M. D. or Coroner
Address: by Sykesville Md. Date signed: 7/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05819

Reg. Dist. No. 24

1. PLACE OF DEATH

County: Carroll Co.

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 3 mo 10 da

Hospital, Institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 3 yrs 3 mo 10 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wash Co.

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Doris Jane Cowden

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 22-1920

8. AGE: Years 24 | Months 11 | Days 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Hagerstown (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER — 12. Name: Hunter B Cowden

13. Birthplace: Hagerstown

MOTHER — 14. Maiden name: Myrtle Long

15. Birthplace: Hagerstown

16. Informant: Mrs Myrtle Jenkins

Address: 211 High St. Hagerstown

17. Burial (Burial, cremation, or removal, Which?) Date thereof 6-8-45 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraine

Address: Hagerstown, Md.

19. June 6 1945 C. Harry Rees

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6th 1945, at 1-30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1942, to June 6th 1945

and that I last saw her alive on June 6th 1945

Immediate cause of death: ..... DURATION

Due to: Syphilitic Meningo Encephalitis — 3 yrs

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. D. Gaston M.D.

M. D. or other

Address: Sykesville Md. Date signed 6/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

05920

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs 5 mo 29 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 24 yrs 5 mo 29 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montg.

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Pierce Crown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 9th - 1875

8. AGE:

Years	Months	Days	If less than one day
69	9	11	____ hrs. ____ min.

9. Birthplace: Maryland.
(Town, county, and state)

10. Usual occupation: Dependent.

11. Industry or business:

FATHER — 12. Name: Hamilton Crown

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Sallie Allen

15. Birthplace: Maryland.

16. Informant: Mrs. Ethel Whalen

Address: Hungerford Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-24-45 (month) (day) (year)

Cemetery or crematory: Forest Oak Cem.

Location: Gaithersburg, Md.

18. Funeral director: Roy W. Barber

Address: Laytonsville, Md.

19. June 22 1945 (Date rec'd by registrar) C. Harry Wells Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1920, to June 24 1945 and that I last saw h[illegible] alive on June 24 1945

Immediate cause of death	DURATION
Lobar Pneumonia	4 da
Due to:	
Epilepsy	9
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 6/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

05921

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months. 13 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Catherine St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LENA DASHIELDS

3.(b) Social Security Number: 213-24-0884

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 30, 1930

8. AGE:	Years	Months	Days	If less than one day
	15	2	9	hrs. min.

9. Birthplace: Salisbury, Md. (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business: at school
MOTHER FATHER
12. Name: Marvin Dashields
13. Birthplace: Salisbury, Md.
MOTHER
14. Maiden name: Mabel Pinkney
15. Birthplace: Salisbury, Md.
16. Informant: George G. Adams, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10 - 1945 (month) (day) (year)
Cemetery or crematory: Salisbury
Location: Salisbury Md
18. Funeral director: Franklin P. Stewart
Address: Salisbury Md
19. 6/8/ (Date rec'd by registrar) 19 45 Alfred L. Frankhauser Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1945, at 7.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26, 1945, to June 8, 1945 and that I last saw her alive on June 8, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George G. Adams MD M. D. or other
Address: Henryton, Md. Date signed 6/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05923

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 9 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5710 Condor Lane
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SAMUEL ARTHUR DIGGS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 15, 1943

8. AGE: Years	Months	Days	If less than one day
1	1D	29	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Samuel Diggs
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Emily Johnson
15. Birthplace: Virginia

16. Informant: George G. Adams, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15th, 1945 (month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: Baltimore Md

18. Funeral director: Edwin O Wilson
Address: 1000 Brantley Ave

19. 6/13/45 (Date rec'd by registrar) 19 Albert R. Sandman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13, 1945 at 9.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4, 1945 to June 13, 1945 and that I last saw him alive on June 13, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George G. Adams MD M. D. or other
Address: Henryton, Md. Date signed 6/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05922

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 911 Bevan Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: SUSIE DINGER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec., 25, 1919

8. AGE:	Years	Months	Days	If less than one day
	25	5	12	hrs. min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business: Unknown

FATHER
12. Name: James Rowe
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/7/45 (month) (day) (year)
Cemetery or crematory: Manning
Location: S C
18. Funeral director: Isaac L. Brownsberger
Address: Balto. Md.

19. 6/6/ 19 45 (Date rec'd by registrar) Albert R. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 1945, at 8.45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9, 1945, to June 6, 1945 and that I last saw her alive on June 6, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Feb. 15 1945

Due to:

Due to:

Other conditions:

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D.
M. D. or other
Address: Henryton, Md. Date signed: 6/6/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05924

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 11 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Marion Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lover's Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY ETTA EWELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 14, 1926

8. AGE:	Years	Months	Days	If less than one day
	19	0	23	hrs. min.

9. Birthplace: Marion Station, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown

FATHER
12. Name: John Ewell
13. Birthplace: Pocomoke City, Md.

MOTHER
14. Maiden name: Beulah Dennis
15. Birthplace: Pocomoke City, Md.

16. Informant: C. D. Lee, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10-1945 (month) (day) (year)
Cemetery or crematory: Waters Chapel
Location: Morgan Station, Md
18. Funeral director: Chas S. Ward
Address: Marion Station, Md

19. 6/6 (Date rec'd by registrar) 19 45 Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 19 45, at 6.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26, 19 44, to June 6, 19 45 and that I last saw her alive on June 6, 19 45

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. D. Lee M. D.
M. D. or other
Address: Henryton, Md. Date signed: 6/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05925

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Taylors Island
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARGIE FIELDS

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife: Louis Fields
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1898

8. AGE: Years	Months	Days	If less than one day
47	3	1	..... hrs. ..... min.

9. Birthplace: Taylors Island, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: William Hooper
13. Birthplace: Taylors Island, Md.

MOTHER
14. Maiden name: Ada Hooper
15. Birthplace: Taylors Island, Md.

18. Informant: George G. Adams, M. D.
Address: Henryton, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 6-15-45 (month) (day) (year)
Cemetery or crematory: Cemetery,
Location: Taylor Island md.
18. Funeral director: Selvis A. Henry,
Address: Cambridge md.

19. 6/13 (Date rec'd by registrar) 19 45 Albert R. Swankhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13, 19 45, at 1.20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9, 19 45 to June 13, 19 45 and that I last saw her alive on June 13, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: George G. Adams M.D. M. D. or other
Address: Henryton, Md. Date signed: 6/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 05926 74

Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 6 mo's, 5 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Glenwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARSHALL I. FISHER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept., 13, 1925

8. AGE:	Years	Months	Days	If less than one day
	19	9	8	hrs. min.

9. Birthplace: Roxbury, Maryland. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Gilbert Fisher
13. Birthplace: Unknown

MOTHER
14. Maiden name: Fanny Fisher
15. Birthplace: Unknown

16. Informant: C. D. Lee, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/29/45 (month) (day) (year)
Cemetery or crematory: Howard Chapel
Location: Montgomery Co. Md.
18. Funeral director: H. M. Snyder
Address: Mt. Airy

19. 6/26/45 (Date rec'd by registrar) 19 Albert R. Swanhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26, 1945, at 3.25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 21, 1943 to June 26, 1945 and that I last saw him alive on June 26, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Dec. 1943
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. D. Lee M. D. M. D. or other
Address: Henryton, Maryland. Date signed: 6/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

05927

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Rural Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Taneytown,
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John T. Fleming

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Romaine Fleming

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 17, 1890

8. AGE: Years	Months	Days	If less than one day
55	4	16	hrs. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Samuel Fleming

13. Birthplace Maryland

MOTHER 14. Maiden name Alberta Davis

15. Birthplace Maryland

16. Informant Mrs. John T. Fleming

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/5/45 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Uniontown, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. June 5- 1945 (Date rec'd by registrar) Ethel M Metzing Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1945, to June 2 1945 and that I last saw him alive on June 2 1945

Immediate cause of death	DURATION
Acute myocarditis	
Due to Chronic Asthma	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Uniontown, Md. Date signed 6-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05928

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 12 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Church Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LONNIE FRANKLIN

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Annie Franklin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20, 1895

8. AGE: Years	Months	Days	If less than one day
49	10	22	hrs. min.

9. Birthplace: Barnesville Co., S. C. (Town, county, and state)
10. Usual occupation: Plasterer
11. Industry or business: Unknown
FATHER 12. Name: ~~C. A. Lee, M. D.~~ Jerry Franklin
13. Birthplace: Henryton, Md. S. C.
MOTHER 14. Maiden name: Margie Kirres
15. Birthplace: South Carolina
16. Informant: ~~Jerry Franklin~~ C. A. Lee, M.D.
Address: ~~South Carolina~~ Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/17/45 (month) (day) (year)
Cemetery or crematory: Woodbine Memorial Park
Location: Baltimore, Md.
18. Funeral director: Mrs Katie R. Williams
Address: 322 N. Schroeder St
19. 6/12 (Date rec'd by registrar) 19 45 Albert R. Lowman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12, 1945 at 7.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1945 to June 12, 1945 and that I last saw him alive on June 12, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. A. Lee M. D. M. D. or other
Address: Henryton, Md. Date signed: 6/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

05928 Reg. Diat. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL PLEASANT VALLEY
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 MONTHS

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: RURAL PLEASANT VALLEY
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES E. FUHRMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6.(b) Name of husband or wife: SARAH H. EIKER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JULY 25, 1854

8. AGE:

Years	Months	Days	If less than one day
90	10	21	..... hrs. ..... min.

9. Birthplace: AVONDALE, MD.
(Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business

FATHER
12. Name: SAMUEL FUHRMAN
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: MARY KNIPPLE
15. Birthplace: MARYLAND

16. Informant: MRS. B.F. KIMPLER
Address: PLEASANT VALLEY, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 6/18/45 (month) (day) (year)

Cemetery or crematory: KRIDER'S CEMETERY

Location: WESTMINSTER, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 6/16 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JUNE 15 19 45, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 19 45, to June 14th 19 45; and that I last saw h. alive on June 13th 19 45.

Immediate cause of death	DURATION
Myocardial Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John J. Stewart M. D. or other

Address: Westminster Md. Date signed: June 16 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

05930

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 11 mo., 25 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Frederick Pike
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WILLIAM JOSEPH FULLER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 11, 1908

8. AGE: Years	Months	Days	If less than one day
36	9	29	hrs. min.

9. Birthplace: Ellicott City, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: William H. Fuller

13. Birthplace: Ellicott City, Md.

MOTHER — 14. Maiden name: Clementine Mosley

15. Birthplace: Charlottesville, va.

16. Informant: C. D. Lee, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-13-45 (month) (day) (year)

Cemetery or crematory: Fuller Cemetery

Location: Ellicott City Md.

18. Funeral director: H. C. Higinbothom

Address: Ellicott City. Md.

19. June 9, 1945 (Date rec'd by registrar) Alberta Higinbothom Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9, 1945, at 9:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1942, to June 9, 1945 and that I last saw him alive on June 9, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1938
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. D. Lee, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 6-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

FILM No. C 95 JUN 13 1945
FILM No. C 96 JUN 27 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05931

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 9 mos 10 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs 9 mos 10 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Sadie Hazel Gary

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12th - 1904

8. AGE: Years: 40 41- 40 | Months: 10 8 | Days: 24 24 | If less than one day: hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Dependent.

11. Industry or business: Thomas

FATHER 12. Name: Wilson T. Gary

13. Birthplace: Md

MOTHER 14. Maiden name: Sadie ~~Eugene~~ Virginia Johnson Gary

15. Birthplace: Md

16. Informant: Wilson Eugene Gary

Address: 2010 Mt Royal Terrace Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-7-45 (month) (day) (year)

Cemetery or crematory: London Park Cemetery

Location: Frederick Road - Baltimore, Md.

18. Funeral director: William Cook Inc

Address: 1217 St Paul Street

19. June 6 1945 C. Harry Weber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6th 1945 at 11-45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 1941 to June 6th 1945 and that I last saw her alive on June 6th 1945

Immediate cause of death	DURATION
Bronchopneumonia	3 da
Due to	
Due to Epilepsy.	40 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 6-6-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

05932

Reg. Dist. No. 76.

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 RIDGE ROAD

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME RUTH ANNA GOTTLIEB

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCTOBER 4, 1866

8. AGE: Years 78 | Months 8 | Days 24 | If less than one day ... hrs. ... min.

9. Birthplace LUDLOW, KENTUCKY (Town, county, and state)

10. Usual occupation RETIRED SCHOOL TEACHER

11. Industry or business

FATHER 12. Name FREDERICK A. GOTTLIEB

13. Birthplace NOT KNOWN

MOTHER 14. Maiden name VIRGINIA HARWOOD

15. Birthplace NOT KNOWN

16. Informant MRS. A. M. ISANOGLE

Address WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 6/30/45 (month) (day) (year)

Cemetery or crematory HIGHLAND CEMETERY

Location COVINGTON, KENTUCKY

18. Funeral director V. FRANCIS REESE

Address WESTMINSTER, MD.

19. 6/28/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 28 19 45, at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 19 45, to June 28 19 45

and that I last saw h... alive on June 28 19 45

Immediate cause of death	DURATION
(a) Cer. Cerebral Hemorrhage	48 hrs.
Due to: Diabetes Mellitus	15 years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter Ben (M.D.)

M. D. or other

Address Westminster, Md. Date signed 6/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-F)

CERTIFICATE OF DEATH

05937

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster No. 3

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster No. 3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clayton Stanley Groft

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Bertie Mae Groft

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12 - 1885

8. AGE: Years	Months	Days	If less than one day
60	3	12	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER — 12. Name Samuel Groft

13. Birthplace Md.

MOTHER — 14. Maiden name Emma Wilhide

15. Birthplace Md.

16. Informant Mrs. Estella Groft

Address Westminster, Md. 1945

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2 - 1945 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 6/30 (Date received by registrar) 19 45 - L K Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 45 - at 5:15 - A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 19 45 to June 28 19 45 -

and that I last saw h...i...v...alive on June 27 - 19 45 -

Immediate cause of death	DURATION
Myocarditis (Chr)	2
Nephritis (Chr)	3
Due to	
Due to	
Other conditions Acute gastritis	2 dy

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Bennett M.D., M. D. or other

Address Westminster Md. Date signed 6-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore

CERTIFICATE OF DEATH

★ 05934

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 8 mo., 1 day

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 218 N. Bradford St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES LOUIS GROSS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12, 1942

8. AGE:	Years	Months	Days	If less than one day
	2	11	0	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Leander Gross
13. Birthplace: Unknown

MOTHER
14. Maiden name: Hattie Pressbury
15. Birthplace: Maryland

16. Informant: George Adams, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16th 1945 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: Brooklyn, Md.

18. Funeral director: Edward O. Weiss
Address: 1500 Brantley Ave

19. June 12, 1945 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12, 1945 at 6:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11, 1943 to June 12, 1945 and that I last saw him alive on June 12, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George S. Adams M.D.
M. D. or other
Address: Henryton, Md. Date signed: 6-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

05935

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 14 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 year, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Joseph . Hammer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of ~~husband or~~ wife: Ella T. Hammer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): October 3rd 1871

8. AGE: Years	Months	Days	If less than one day
73	8	17	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Retired Clerk
11. Industry or business: Insurance
FATHER 12. Name: John Hammer
13. Birthplace: Germany
MOTHER 14. Maiden name: Kunigunda (unknown)
15. Birthplace: Germany
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23, 1945 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cemetery
Location: Balto. Md.
18. Funeral director: Williams Cook Inc
Address: 1217 St. Paul St.
19. June 30 1945 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION a

20. DATE OF DEATH: June 20 19 45 at 10:40 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 19 45 to June 20 19 45
and that I last saw him alive on June 20 19 45

Immediate cause of death	DURATION
Coronary occlusion	3 mo.
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Address: Sykesville, Maryland Date signed 6-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05936

Reg. Dist. No. 7J

1. PLACE OF DEATH:
County CARROLL
City or town HARNEY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Harney
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Cora M. Hankey

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife William P. Hankey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 26, 1878

8. AGE: Years	Months	Days	If less than one day
66	9	27	..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Bowers
13. Birthplace Md.

MOTHER
14. Maiden name Ella Hyser
15. Birthplace Md.

16. Informant William P. Hankey
Address Taneytown, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26, 1945 (month) (day) (year)
Cemetery or crematory United Brethren
Location Harney

18. Funeral director C. O. FUSS & SON
Address Taneytown, Md.

19 June 25 1945 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 rd 1945, at 2:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19th 1945 to June 23 rd 1945 and that I last saw h.. alive on June 22nd 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 weeks
Due to	
Due to	
Other conditions Arteriosclerosis with Paralysis. (Include pregnancy within 3 months of death)	8 yrs.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. M. Benner M.D. M. D. or other
Address Taneytown Md Date signed June 23 rd 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for additon of color of deceased is shown on FILM No. G 96

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12th)

CERTIFICATE OF DEATH

05940

Reg. Dist. No. 75

JUN 23 1945

1. PLACE OF DEATH:
County Carroll
City or town Manchester Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Entire Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Agnes Hurley

3.(b) Social Security Number None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Charles Hurley
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 14, 1852
8. AGE: Years 92 | Months 11 | Days 25 | If less than one day: hrs. min.
9. Birthplace: Harrons Pa. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home
FATHER 12. Name: Augustus Brickler
13. Birthplace: Harrons Pa
MOTHER 14. Maiden name: Mary Ann Mueller
15. Birthplace: Harrons Pa
16. Informant: Mrs Howard Lasley
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-12-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Winks Sons
Address: Manchester Md.
19. June 11 1945 Wm. W. G.S. Denver (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1945, at 8.50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3, 1945, to June 9, 1945 and that I last saw h.r. alive on June 9 1945

	DURATION
Immediate cause of death: Intestinal Obstruction	
Due to: Not due to cancer. cause. Intussusception	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Jos. E. Buehler M.D. M. D. or other
Address Manchester Md Date signed 6/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 059381.

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mt Union
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Haybarst

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: David Haybarst
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): November 22 - 1871
8. AGE: Years: 73 Months: 5 Days: 28 If less than one day: ____ hrs. ____ min.
9. Birthplace: West Virginia Marion Co. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at Home
FATHER 12. Name: Joseph Williams
FATHER 13. Birthplace: West Virginia
MOTHER 14. Maiden name: Not Known
MOTHER 15. Birthplace: Not Known
16. Informant: Raymond Haybarst
Address: Union Bridge Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22 - 1945 (month) (day) (year)
Cemetery or crematory: Mt Union Cemetery
Location: Near Middleburg Md
18. Funeral director: D. D. Hartlaub Son
Address: Union Bridge & New Windsor Md.
19. June 21 1945 (Date rec'd by registrar) B. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1945, at 7.15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-10 1945 to 6-19-1945
and that I last saw her alive on 6-18- 1945
Immediate cause of death: Arteriosclerosis

	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. N. Lugg M. D. or other
Address: Union Bridge Date signed: 6/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05938

Reg. Dist. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elmer S. Hess

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lydia E. Hess

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 22, 1867

8. AGE:	Years	Months	Days	If less than one day
	78	2	7	..... hrs. ..... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER — 12. Name: H. David Hess

FATHER — 13. Birthplace: Carroll County, Md.

MOTHER — 14. Maiden name: Ellen Shoemaker

MOTHER — 15. Birthplace: Frederick County, Md.

16. Informant: Mr. Carroll Hess

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 1, 1945 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Taneytown, Md.

18. Funeral director: C.O. Fuss & Son

Address: Taneytown, Md.

19. June 30 1945 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1945 at 4:55a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 1940 to June 27 1945 and that I last saw h... 1m ... alive on June 27 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Arteriosclerosis and hypertension	15 yrs.
Due to:	
Other conditions: Chronic myocarditis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M.D.
M. D. or other

Address: Taneytown, Md. Date signed: 6.30.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05939

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Hurlock (If outside city or town limits, write RURAL and give nearest town)
Street No. Pickle House Shacks (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME: WILLIE HILL

3. (b) Social Security Number: 225-09-4860

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug., 6, 1907

8. AGE: Years	Months	Days	If less than one day
37	10	1	..... hrs. ..... min.

9. Birthplace: Roper, N. C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown
FATHER 12. Name: Junious Hill
FATHER 13. Birthplace: Franklin, Va.
MOTHER 14. Maiden name: Minnie Hudson
MOTHER 15. Birthplace: North Carolina
16. Informant: C. D. Lee, M. D.
Address: Henryton, Md.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 6/8/45 (month) (day) (year)
Cemetery or crematory University of Md Medical School Morgue
Location Baltimore, Md.
18. Funeral director Mrs Samuel J Hemsley
Address 578 N. Biddle St
19. 6/7 19 45 (Date rec'd by registrar) Albert D. Swanhaw Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1945 at 6.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1945 to June 7 1945 and that I last saw him alive on June 7, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec., 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. D. Lee M. D. M. D. or other
Address Henryton, Md. Date signed 6/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on FILM No G 95 JUN 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-C)

CERTIFICATE OF DEATH

05941

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 6 mos. 6 da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs. 6 mos. 6 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1302 Linden Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ward Holland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife (maiden name) Holland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 3, 1887

8. AGE: Years	Months	Days	If less than one day
58 55	2	4	..... hrs. ..... min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name John Rogers

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Emma Cooper

15. Birthplace Baltimore Md

16. Informant Hospital Records

Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 9, 1945 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto. Md.

18. Funeral director Williams Cook, Inc.

Address 1217 St. Paul St.

19. June 8 1945 C. Harry Klee (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7th. 1945, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-9- 1943, to 6-7- 1945 and that I last saw h[illegible] alive on 6-7- 1945

Immediate cause of death	DURATION
Post encephalitis	13 yrs.
Due to Parkinsons Syndrome	
Due to	
Other conditions Psychosis with organic brain disease (Include pregnancy within 3 months of death)	4 yrs.

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Hans M Rees M.D. M. D. or other

Address Sykesville Md Date signed 6-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

(1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

05942

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alice Virginia Jenkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife Elmer C. Jenkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 28, 1866

8. AGE: Years	Months	Days	If less than one day
78	11	24	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name James Easton

13. Birthplace Md.

MOTHER 14. Maiden name Sarah L. Shipley

15. Birthplace Md.

16. Informant Mrs. Bertha Carter

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24, 1945 (month) (day) (year)

Cemetery or crematory Eldersburg Cemetery

Location Winfield, Carroll Co. Md.

18. Funeral director C. Harry Wiley

Address Sykesville, Md.

19. June 23 1945 (Date rec'd by registrar) C. Harry Wiley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to June 22 1945 and that I last saw h.. alive on June 21 1945

Immediate cause of death	DURATION
Cardio vascular Renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. H. Barnes M.D.

M. D. or other

Address Sykesville Md. Date signed 6-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05943

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs., 3 mos., 11 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 4 yrs., 3 mos., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 2132 Hollins St. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edward Percy Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella Jones
6.(c) If alive, give age: unknown years
7. Birth date of deceased (mo., day, yr.): September 7, 1870

8. AGE: Years	Months	Days	If less than one day
74	9	23	...hrs. ...min.

9. Birthplace: Anne Arundel Co., Maryland (Town, county, and state)
10. Usual occupation: Watchman
11. Industry or business: ?

FATHER
12. Name: Richard Jones
13. Birthplace: Anne Arundel Co., Md.

MOTHER
14. Maiden name: Elizabeth Owens
15. Birthplace: Anne Arundel Co., Md.

16. Informant: Hospital Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3, 1945 (month) (day) (year)
Cemetery or crematory: Meadow Ridge Mem. Cem.
Location: Washington Blvd.
18. Funeral director: Wm. J. Leitner
Address: North & Pa. ave.
19. June 30 1945 (Date rec'd by registrar) C. Harry Zeller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1945 at 7 07½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1941, to June 30 1945 and that I last saw him alive on June 30 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 yr.
Due to: Chronic Myocarditis	unkn.
Other conditions: Senile Dementia, Hypertension, Senescence	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other
Address: S. Hospital, Sykesville, Md. Date signed: 6-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

05944

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month.
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route #3.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARIE JONES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Robert Jones
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 19, 1923

8. AGE: Years	Months	Days	If less than one day
22	2	29	hrs. min.

9. Birthplace: Rockville, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Daniel Smith
13. Birthplace: Avery, Md.

MOTHER
14. Maiden name: Bertha Johnson
15. Birthplace: Rockville, Md.

16. Informant: George G. Adams, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20 1945 (month) (day) (year)
Cemetery or ~~crematory~~ Norbeck Mem Cemetery
Location Montgomery Co Md
18. Funeral director Roy W Barber
Address Rockville Md
19. 6/17 19 45 H. L. Trunkham Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17, 1945, at 10.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1945 to June 17, 1945 and that I last saw h...er alive on June 17, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George G. Adams M. D. or other
Address: Henryton, Md. Date signed: 6/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05945

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 6 mo's, 25 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1428 Riggs Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CHARLES DAVENPORT JOYNER

3.(b) Social Security Number: 218-10-0863

4. Sex: male

5. Color or race: colored

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Frances Joyner

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): April 14, 1903

8. AGE: Years: 42 Months: 2 Days: 0 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Alvey Joyner
13. Birthplace: Unknown

MOTHER
14. Maiden name: Minnie Warfield
15. Birthplace: Baltimore-Md.

16. Informant: C. D. Lee, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/18/45 (month) (day) (year)

Cemetery or crematory:
Location: Balto Co.

18. Funeral director: Mrs Ger[illegible] Holland
Address: 1631 Druid Hill Ave.

19. 6/14/45 (Date rec'd by registrar) 19 Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14, 1945 at 2.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19, 1943 to June 14, 1945 and that I last saw him alive on June 14, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Aug. 28 1943
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C D Lee M.D. M. D. or other
Address: Henryton, Md. Date signed: 6/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

05946

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Finebro, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Finebro, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME AMOS KERCHNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

8.(b) Name of husband or wife: Amanda Slaubaugh Kerchner
8.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): Feb. 4. 1853

8. AGE: Years: 92 | Months: 4 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: York Co. Pa
(Town, county, and state)

10. Usual occupation: Section Foreman Retired

11. Industry or business: W. M. Rail Road

FATHER
12. Name: Henry Kerchner
13. Birthplace: York Co. Pa.

MOTHER
14. Maiden name: Elizabeth Faudon
15. Birthplace: York Co. Pa.

16. Informant: Edward C. Kerchner
Address: Finebro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 9 1945 (month) (day) (year)
Cemetery or crematory: Finebro, Md.
Location: Fogarus Lutheran
H. C. Leifle

18. Funeral director: Glen Rock, Pa.
Address

19. June 8 1945 Mrs. M. R. S. Donmoyer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 1945, at 9.30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1945, to June 7 1945
and that I last saw him alive on June 5 1945

Immediate cause of death	DURATION
Arteriosclerosis	3 months
Due to: Gangrene of left leg	
Due to:	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. V. Sobler M. D.
M. D. or other
Address: Manchester Md Date signed: 6-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

05947

Reg. Dist. No. 71

VS A15 (T) (1) (M) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Rural (If outside city or town limits, write RURAL and give nearest town) West Minister

How long in above place of death? 34 years

Hospital, institution, or street address where death occurred: Ridge Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near West minister (If outside city or town limits, write RURAL and give nearest town)

Street No.: Ridge Road (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Edward Regan

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	widowed

6.(b) Name of husband or wife: Maria Wahlberg

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 8, 1875

8. AGE:

Years	Months	Days	If less than one day
69	8	0	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Retired Chief Clerk of

11. Industry or business: Consolidation Coal Co.

FATHER 12. Name: Bernard Regan

FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden name: Elizabeth Kamspen

MOTHER 15. Birthplace: Germany

18. Informant: Miss Anna E. Regan

Address: Ridge Road Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/11/45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md.

18. Funeral director: J. E. Myers Jr.

Address: Westminster Md.

19. 6/8/45 (Date rec'd by registrar) 19..... O Ray Eagle Dep. Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1945 at 12:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1945, to June 8, 1945

and that I last saw him alive on June 4 1945

Immediate cause of death	DURATION
Coronary occlusion	3 mos
Due to: arteriosclerosis	Indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E Reese Wilkens M D (M. D. or other)

Address: Westminster Md. Date signed 6/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

05948

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years, 9 months
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 12 years, 9 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: rural near Flint Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: L. Daniel Lenhart

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife: Flora Soper
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 8, 1879

8. AGE: Years	Months	Days	If less than one day
65	8	5	hrs. min.

9. Birthplace: Flint Hill, Frederick Co., Md.
(Town, county, and state)
10. Usual occupation: farmer
11. Industry or business: agriculture
FATHER 12. Name: Ben. F. Lenhart
13. Birthplace: Frederick County, Maryland
MOTHER 14. Maiden name: Maggie Purdy
15. Birthplace: Maryland
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 16, 1945 (month) (day) (year)
Cemetery or crematory: Flint Hill Methodist Cem
Location: Mt. Fredericks, Md.
18. Funeral director: W. K. Etchison & Son
Address: Frederick, Md.
19. June 14 1945 C. Henry Ebert
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 1945 at 4:40p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to June 13 1945 and that I last saw him alive on June 13 1945

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	4 mo.
Due to:	
Due to:	
Other conditions: Post-traumatic personality disorder	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 6-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B5949

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry Little

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

8.(b) Name of husband or wife Clarinda C. Humbird Little
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18 1865

8. AGE:

Years	Months	Days	If less than one day
80	4	24	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Amos Little
13. Birthplace Littlestown, Pa.

MOTHER
14. Maiden name Julia Ann Mathias
15. Birthplace Carroll Co. Md.

16. Informant Sterling Little
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15 1945 (month) (day) (year)
Cemetery or crematory Prides Cemetery
Location Westminster, Md.

18. Funeral director W B Bankard & Son
Address Westminster Md

19. 6/13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1945 to June 12 1945
and that I last saw him alive on June 11 1945

Immediate cause of death Coronary Thrombosis
Due to Angina Pectoris
Due to Age

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward D Lemmon M. D. or other
Address Westminster Md Date signed June 13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

05950

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs 9 mo 29 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 yrs 9 mo 29 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Rose Watley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife: —

B.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Nov 17 - 1898

8. AGE: Years 46 | Months 6 | Days 23 | If less than one day ... hrs. ... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER — 12. Name: John J Watley

13. Birthplace: Md

MOTHER — 14. Maiden name: Anna Schultz

15. Birthplace: Md

16. Informant: John J. Watley

Address: 5622 Greenhill Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1945 (month) (day) (year)

Cemetery or crematory: Sacred Heart Cem.

Location: Balto Md.

18. Funeral director: Lilly & Zeiler Inc.

Address: 403 S. Wolfe St.

19. June 9 1945 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9th 1945, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1937 to June 9th 1945 and that I last saw h.. alive on June 9th 1945

Immediate cause of death: Acute Hemorrhage Pancreatitis

	DURATION
Due to: Pancreatitis	2 da
Due to: Cholecystolithiasis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy findings: Acute Hemorrhagic Pancreatitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: W. H. Haslin M.D. M. D. or other

Address: Sykesville Md. Date signed: 6/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

05951

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr., 8 mo., 28 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: rural near Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Emanuel Meisel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 7, 1877

8. AGE: Years	Months	Days	If less than one day
68	0	13	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Agriculture

FATHER
12. Name: John Meisel
13. Birthplace: Germany

MOTHER
14. Maiden name: Yske -
15. Birthplace: Germany

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25, 1945 (month) (day) (year)
Cemetery or crematory: Dayton
Location: Dayton, Ohio
18. Funeral director: Williams Cook Inc.
Address: 1217 St. Paul St. Balto. Md.
19. June 20 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 19 45 at 6:01a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to June 20 19 45 and that I last saw him alive on June 19 19 45

Immediate cause of death	DURATION
Arteriosclerosis, prior to	1942
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 6-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

05952

Reg. Diat. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Lloyd Miller

3.(b) Social Security Number V

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

8.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) June 12 - 1945
6.(c) If alive, give age ..... years

8. AGE:

Years	Months	Days	If less than one day
—	—	—	1 hrs. ..... min.

9. Birthplace: Hampstead Md
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Melvin G. Miller
13. Birthplace: Md

MOTHER
14. Maiden name: Julia J. Murray
15. Birthplace: Md

16. Informant: Melvin J. Miller
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17 45 (month) (day) (year)
Cemetery or crematory: Hampstead
Location: Hampstead, Md
19. Funeral director: Edw. C. Tipton
Address: Hampstead Md

19. June 12 1945 John S. Hughes Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 1945, at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1945, to June 12 1945 and that I last saw him alive on June 12 1945

Immediate cause of death	DURATION
Pre-Maturity	6 hrs about
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Maurice C. Partenheimer M. D. or other
Address Hampstead Md Date signed 6-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

CERTIFICATE OF DEATH

05953

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs 9 mos 20 da.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 34 yrs 9 mos 20 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 E. Fayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Johanna Morris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife (McKinnon) Morris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) (Feb. 4 day unk.) 1855.

8. AGE:

Years	Months	Days	If less than one day
90			..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name W. B. Smith
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Elizabeth Wiginer
15. Birthplace Ireland

16. Informant Hospital Records
Address Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/30/45 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Sykesville, Md.

18. Funeral director C. Harry Klee

Address Sykesville, Md.

19. June 29 1945 C. Harry Klee
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945 at 9.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945 to June 27 1945 and that I last saw h[illegible] alive on June 27 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to	
Due to General Arteriosclerosis	11 yrs
Other conditions Organic Condition	35 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Maud M. Rees M.D.
M. D. or other

Address Sykesville Md. Date signed 6-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

05954

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 17 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Camp Parole
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ELIZABETH BUTLER PARKER

3.(b) Social Security Number: 219-12-4558

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Widow

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept., 15, 1918

8. AGE:	Years	Months	Days	If less than one day
	26	8	26	hrs. min.

9. Birthplace: Mayo, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Lewis Butler
13. Birthplace: Hope Chapel, Md.

MOTHER — 14. Maiden name: Sarah Cotes
15. Birthplace: Carroll County, Md.

16. Informant: George G. Adams
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1945 (month) (day) (year)

Cemetery or crematory: Hope Chapel Cem.

Location: Edgewater, Md

18. Funeral director: H. C. Standiford & Son

Address: Galesville, Md.

19. 6/10 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10, 1945, at 2.40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24, 1945 to June 10, 1945 and that I last saw her alive on June 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George G Adams M.D. M. D. or other

Address: Henryton, Md. Date signed: 6/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 05955 70

1. PLACE OF DEATH:

County Carroll

City or town Rural-Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural- Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ida M. Reaver

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Franklin P. Reaver

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1865

8. AGE: Years	Months	Days	If less than one day
80	1	23	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Ephriam D. Hess

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Hannah J. McGuigan

MOTHER 15. Birthplace Maryland

16. Informant Ervin Reaver

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-6-45 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Taneytown, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. June 6 1945 Ethele M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1945, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1911, to June 3rd 1945

and that I last saw her alive on June 3rd 1945

Immediate cause of death	DURATION
Diabetes mellitus	7yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis J. Elliot M.D.
M. D. or other

Address Taneytown, Maryland Date signed 6/4/'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 059506

1. PLACE OF DEATH:
County Carroll.
City or town Westminster.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred: Methodist Home for aged
How long in hospital or institution? 3 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll.
City or town Westminster.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Church & Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Leah Louise Rosier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

8.(b) Name of husband or wife Unknown.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 20, 1869.

8. AGE: Years	Months	Days	If less than one day
75	6	27.	..... hrs. ..... min.

8. Birthplace Baltimore Co. Md.
(Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business

FATHER 12. Name Thomas R. Downs.
13. Birthplace Md.

MOTHER 14. Maiden name Mrs. Susannah Shaver
15. Birthplace Md.

16. Informant Methodist Church Home
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19 1945 (month) (day) (year)
Cemetery or crematory New Market
Location Md. Line, Balto. Co., Md.

18. Funeral director Jacob Hartenstein
Address New Freedom, Pa.

19. 6/19 19 45 H L Brumbaugh
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8th 1945 to June 17 1945
and that I last saw h[illegible] alive on June 16 1945

Immediate cause of death Cerebral Thrombosis — DURATION 10 days
Due to General Arteriosclerosis — 3 yrs
Due to
Other conditions Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H L Brumbaugh M. D. or Other
Address Westminster Date signed 6/17/45

VS A15

PLEASE WRITE PLAINLY, WITH INDELIBLE FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05957 — Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr., 1 mo., 13 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 yr., 1 mo., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Maurice W. Rother

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Gertrude A. Wiscott Rother
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 6, 1883

8. AGE: Years	Months	Days	If less than one day
62	5	4	hrs. min.

9. Birthplace: Chester, Pennsylvania (Town, county, and state)
10. Usual occupation: Machinist (Retired
11. Industry or business: -

FATHER — 12. Name: Henry Rother
13. Birthplace: Germany

MOTHER — 14. Maiden name: Katherine McGlenn
15. Birthplace: Ireland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/13/45 (month) (day) (year)
Cemetery or crematory: Immanuel Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 6/11/45 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 19 45 at 12:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 43, to June 10 19 45 and that I last saw him alive on June 10 19 45

Immediate cause of death	DURATION
Cerebral thrombosis	4 days
Due to: Arteriosclerosis	13 yrs.
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 6-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

05958

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred:

115 Penna. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 Pennsylvania Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bertha Verona Saltzgaver

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	divorced

6.(b) Name of husband or wife William H. Saltzgaver

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1895

8. AGE: Years	Months	Days	If less than one day
50	4	15	..... hrs. ..... min.

9. Birthplace Jacobus, York Co., Pa.
(Town, county, and state)

10. Usual occupation seamstress

11. Industry or business

FATHER
12. Name Leo Boyer
13. Birthplace Penna.

MOTHER
14. Maiden name Maggie E. Baumgardner
15. Birthplace Penna.

16. Interment Miss Julia L. Saltzgaver

Address 115 Penna. Ave. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/9/45 (month) (day) (year)

Cemetery or crematory St. Jacobs Lutheran Cem.

Location York Rd. Salem, York Co. Pa.

18. Funeral director J. E. Myers, Jr.

Address Westminster Md.

19. 6/6 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1944 to June 5 1945 and that I last saw her alive on June 5, 1945

Immediate cause of death	DURATION
Coronary occlusion	1 hour
Due to	
Due to	
Other conditions Auricular fibrillation (not continuous)	1 year ±

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reese Wilbern M. D. or other

Address Westminster Md. Date signed 6-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

T 05959

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-E

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs., 10 mos., 28 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 17 yrs., 10 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideuce of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 363 Evesham Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ruth Schwartze

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Not known

8. AGE: Years	Months	Days	If less than one day
47?			hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Telephone Operator
11. Industry or business: ------

FATHER
12. Name: James W. Schwartze
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Annie E. Gough
15. Birthplace: Baltimore, Md.

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4, 1945 (month) (day) (year)
Cemetery or crematory: Parkwood Cemetery
Location: Balto. Md.
18. Funeral director: William Cook, Inc.
Address: 1217 St. Paul St.

19. June 2 1945 C. Harry Weed
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1, 1945 19 at 2:20a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 19 44, to June 1st 19 45 and that I last saw her alive on June 1st 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 yrs.
Due to	
Due to	
Other conditions Dementia Praecox — Katatonic Type	12 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward F Kernan M. D. or other
Address: Sykesville, Md. Date signed 6/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05960

Reg. Dist. No. 75

VS A15 (1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occured:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Thomas J. Shaffer

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret V. Shaffer
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Nov. 6. 1869

8. AGE:

Years	Months	Days	If less than one day
75	7	2	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
12. Name of father: Noah Shaffer
13. Birthplace of father: Maryland
14. Maiden name of mother: Rebecca Gingerich
15. Birthplace of mother: Maryland
16. Informant: Margaret V. Shaffer
Address: Manchester. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-10-45 (month) (day) (year)
Cemetery or crematory: cemetery
Location: Manchester Md
18. Funeral director: Jacob Wentz's Sons
Address: Manchester. Md.
19. June 9 (Date rec'd by registrar) 1945 Wm. M. R. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7th 1945, at 2:20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1944, to June 7 1945
and that I last saw him alive on June 5th 1945

Immediate cause of death	DURATION
Cardiac failure	
Due to Myocardial degeneration	3 yrs
Due to Arterio-sclerotic	
Other conditions Adenoma of prostate gland	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Ludwig Victor Zobler M.D. M. D. or other
Address: Manchester Md Date signed 6-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

05961

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Mary Ellen Shaw

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Wm A. Shaw
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 22, 1864

8. AGE: Years	Months	Days	If less than one day
81	1	18	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
12. FATHER Name: Peter H Smith
13. Birthplace: Md
14. MOTHER Maiden name: Margaret E. Rowe
15. Birthplace: Md
16. Informant: Mrs. E. Romaine Graham
Address: Union Bridge R. #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/11/45 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Uniontown Md
18. Funeral director: C. Russ Bair
Address: Taneytown Md.
19. 6/10/45 (Date rec'd by registrar) Margaret R. Eyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 1945, at 9:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1945, to June 9 1945
and that I last saw her alive on June 8 1945

Immediate cause of death	DURATION
Generalized arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James F. Shaw M. D. or other
Address: Taneytown Md Date signed 6/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bmd)

CERTIFICATE OF DEATH

05962

Reg. Dist. No. 80

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Hanna M. B. Shunk

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 3 - 1870

8. AGE: Years: 74 | Months: 9 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: School teacher
11. Industry or business: Retired
FATHER 12. Name: Benjamin Shunk
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Newcomer
15. Birthplace: Maryland
16. Informant: Mrs Elsie L Ensor
Address: New Windsor Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10 - 1945 (month) (day) (year)
Cemetery or crematory: Presbyterian Cem.
Location: New Windsor Md.
18. Funeral director: C. M. Hartzler & Sons
Address: Union Bridge & New Windsor, Md
19. June 8 1945 (Date rec'd by registrar) Emma B Bunk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 1945 at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 1945 to June 8 1945 and that I last saw h.. alive on June 7 1945

Immediate cause of death: Cerebral Hemorrhage — DURATION: 8 days.
Due to: Arteriosclerotic heart - Pancreatic disease
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: James T Shunk M. D. or other
Address: Westminster Md Date signed 6/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

05963

Reg. Dist. No. 71

1. PLACE OF DEATH:
County Carroll
City or town Rural-Linwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural-Linwood
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles John Spielman, Sr.

3.(b) Social Security Number 213-24-8017

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Catherine Baker Spielman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 10, 1874

8. AGE: Years	Months	Days	If less than one day
70	8	3	....hrs. ....min.

9. Birthplace Linwood, Carroll County, Maryland (Town, county, and state)
10. Usual occupation Cappenter
11. Industry or business

FATHER
12. Name Henry Spielman
13. Birthplace Germany

MOTHER
14. Maiden name Amelia Sittig
15. Birthplace Germany

16. Informant Mrs. Charles Spielman
Address Linwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)
Cemetery or crematory Winter's Cemetery
Location Nr. Linwood, Md.

18. Funeral director C. O. Fuss & Son
Address Taneytown, Md.

19. June 15 1945 (Date rec'd by registrar) Margaret R. Engler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1945, to June 13 1945
and that I last saw h...im alive on June 13 1945

Immediate cause of death	DURATION
Cardiac occlusion	
Due to arteriosclerosis	
Due to Myocardial degeneration	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. J. N. Lugg M. D. or other
Address Mexico Date signed 6-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
JUN 19 1965
BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9

CERTIFICATE OF DEATH

Reg. Diat. No. 596478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Taneytown R.D.1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Since Birth
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown R.D.1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Grace Staub

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): Feb. 20 - 1945
8. AGE: Years 0 Months 4 Days 1 If less than one day hrs. min.
9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business: Infant
FATHER 12. Name: Clayton Staub
13. Birthplace: Frederick Co. Md.
MOTHER 14. Maiden name: Ruth Reaver
15. Birthplace: Carroll Co. Md.
16. Informant: Clayton Staub
Address: Taneytown, Md R.D.1
17. Burial (Burial, cremation, or removal. Which?) Date thereof June. 23 - 1945 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Taneytown, Md.
18. Funeral director: C. M. Teeter & Son
Address: Uniontown, Pa R.D.1 P.A.
19. June 21. 1945 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at 12:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945, to June 21 1945 and that I last saw h.er alive on June 20th 1945

	DURATION
Immediate cause of death: Bronchial Pneumonia	6 days
Due to:	
Due to:	
Other conditions: Whooping Cough	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

22. SIGNATURE C. M. Benner M D
M. D. or other
Address Taneytown Md Date signed June 21 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05965

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2029 Brunt St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LAFAYETTE SYLVESTER WALL

3.(b) Social Security Number: 237-28-1182

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19, 1916

8. AGE: Years	Months	Days	If less than one day
29	1	17	hrs. min.

9. Birthplace: Lilesville, N.C. (Town, county, and state)
10. Usual occupation: Worker in Canning Factory
11. Industry or business

FATHER
12. Name: Richard Wall
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Hattie Ingram
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. (Burial, cremation, or removal Which?) Date thereof: 6/9/45 (month) (day) (year)
Cemetery or crematory: Lieswille North Carolina
Location:
18. Funeral director: William Batsinas
Address: 6009 Prescott ave. Balto MD.
19. June 5, 1945 (Date rec'd by registrar) Albert R Swanborn Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5, 1945 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16, 1945 to June 5, 1945 and that I last saw him alive on June 5, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec., 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md.
Date signed: 6-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05966

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mo's.
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Venton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SYLVESTER WHITE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lillian White
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): May 7, 1898

8. AGE:	Years	Months	Days	If less than one day
	47	1	20	...hrs. ...min.

9. Birthplace: Venton, Md. (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business

FATHER
12. Name: James White
13. Birthplace: Unknown

MOTHER
14. Maiden name: Bessie (?)
15. Birthplace: Unknown

16. Informant: C. D. Lee, M. D.
Address: Henryton, Maryland.

17. Burial [illegible] (Burial, cremation, or removal. Which?) Date thereof July 1 1945 (month) (day) (year)
Cemetery or crematory: Loretto
Location: Loretto Md
18. Funeral director: Chas H Wood
Address: Marion Md

19. 6/27 (Date rec'd by registrar) 19 45 Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945 at 11.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5, 1945, to June 27, 1945 and that I last saw him alive on June 27 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C D Lee, M.D. M. D. or other
Address: Henryton, Md Date signed 6/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

75967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 12 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 834 Edmondson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RUSSELL HENRY WHITTAKER

3.(b) Social Security Number: 218-01-8963

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21, 1903

8. AGE: Years	Months	Days	If less than one day
41	10	13	hrs. min.

9. Birthplace: Enfield, N. Carolina
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER — 12. Name: Henry Whittaker

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Priscilla Sea

15. Birthplace: Enfield, N.C.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8 1945 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem.

Location: Baltimore

18. Funeral director: Mrs. Hattie R. Williams

Address: 322 N. Schroeder St

19. June 3, 1945 (Date rec'd by registrar) Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3, 1945, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 22, 1945 to June 3, 1945 and that I last saw him alive on June 3, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed: 6-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05968

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 10 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1304 Myrtle Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SYLVESTER WOODS

3.(b) Social Security Number: 213-10-8604

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 24, 1898

8. AGE: Years	Months	Days	If less than one day
47	4	29	hrs. min.

9. Birthplace: British West Indies
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Thomas Woods
13. Birthplace: British West Indies

MOTHER
14. Maiden name: Mary Holland
15. Birthplace: British West Indies

16. Informant: C. D. Lee, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/25/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:
18. Funeral director: Joseph B. Locke Jr
Address: 1304 N. Central Ave.

19. June 22, 1945 (Date rec'd by registrar) Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22, 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12, 1945 to June 22, 1945 and that I last saw him alive on June 22, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. D. Lee, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 6-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING